Drs. Campbell Cunningham Taylor & Haun

EyeCare Optical
A Division of Drs. Campbell, Cunningham, Taylor & Haun

HIPAA DISCLOSURE AND ACKNOWLEDGEMENT OF RECEIPT

PATIENT NAME: **DOB:** **DATE:**

HIPAA Privacy Rule gives you the patient the right to request on uses and discloses of your Protected Health Information (PHI). You also have the right to request confidential communications or that of PHI be made by alternative means, such as sending correspondence to an alternate address or call a different phone number than what is listed.

Drs. Campbell, Cunningham, Taylor & Haun has my authorization to contact me in the following manner:

Home Phone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Please only leave a message with: _____ _____
  Contact Person's Name Relationship

Cell Phone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Other:

Work Phone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Other:

Written Communications

- ☐ O.K. to mail to my home address
- ☐ O.K. to fax this number:

Patient Initials: **Date:**

I hereby acknowledge reading the Notice of Privacy Practices and understand that I have the right to obtain a paper copy of this notice.

_____ _____

Date **Signature of Patient / Guardian**